MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
September 18, 2014, 9:30 am to 3:00 pm
Polk County River Place, Room 1
2309 Euclid Avenue, Des Moines, IA
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Thomas Bouska
Neil Broderick
Thomas Broeker
Richard Crouch
Jill Davisson
Marsha Edgington
Lynn Grobe
Kathryn Johnson
Sharon Lambert
Rebecca Peterson
Michael Polich
Marilyn Seemann
Deb Schildroth
Patrick Schmitz
Suzanne Watson

MHDS COMMISSION MEMBERS ABSENT:

Senator Joni Ernst
Senator Jack Hatch
Representative Dave Heaton
Representative Lisa Heddens
Betty King
Geoffrey Lauer
Brett McLain

OTHER ATTENDEES:

April Adams-Knudsen	Eyerly Ball Mental Health Services
Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Bob Bacon (phone)	U of Iowa Center for Disabilities and Development
Jess Benson	Legislative Services Agency
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI Greater DM
Kyle Carlson	Magellan Health Services of Iowa
Marissa Eyanson	Easter Seals
Connie Fanselow	MHDS, Community Services & Planning/CDD
Jim Friberg	Department of Inspections and Appeals
Zeke Furlong	Iowa House Legislative Staff
Karen Hyatt	MHDS, Community Services & Planning
Brandi Jensen	Brain Injury Alliance of Iowa
Ginger Kozak	MHDS, Community Services & Planning
Todd Lange (phone)	Magellan Health Services
Charles Palmer	Director, Iowa Department of Human Services
Cheri Reisner	MHDS, Community Services & Planning
Renee Schulte	DHS Consultant

WELCOME AND CALL TO ORDER

Patrick Schmitz called the meeting to order at 9:40 a.m. and led introductions. Quorum was established with twelve members present. No conflicts of interest were identified for this meeting.

APPROVAL OF MINUTES

Neil Broderick made a motion to approve the minutes of the August 21 meeting as presented. Deb Schildroth seconded the motion. The motion passed unanimously with 12 members present. Lynn Grobe, Sharon Lambert, and Mike Polich joined the meeting after the vote.

CRISIS SERVICES ADMINISTRATIVE RULES

Karen Hyatt and Renee Schulte presented an overview of the administrative rules for the accreditation of providers of crisis response services. DHS is asking the Commission to act on the adoption of the rules today. Currently MHDS accredits providers under Chapter 24 of the Iowa Administrative Code. The rules will be a new division within Chapter 24. Karen explained that the rules have been under development for quite some time and many people have provided input. An MHDS Commission committee has met numerous times, most recently last week, and the members have been very active in reviewing and developing the rules. MHDS accreditation reviewers, Cheri Reisner and Ginger Kozak, have contributed their expertise related to Chapter 24, and current providers of crisis services in Iowa have given feedback. The rules have been published for public comment, and 156 comments were received from six commenters. The commenters included one psychiatrist, one region, and four crisis service providers.

Karen reviewed those comments and responses with the Commission. Some of the comments were statements, including statements of support, some were grammatical in nature, and some were suggestions for changes in content. All the input is appreciated and has helped make the rules better. Karen said she will go over many, but not all, of the changes today. The document is available for review in detail.

Scoring (page 2 of the rules): Changes were made in the number of indicators and the value of indicators to reflect changes made elsewhere in the body of the rules.

General comments (page 5): It was commented that the rules did not address crisis aversion as a service option. DHS responded that it was not included because it was outside the legislative scope of these rules.

"Action plan" definition (page 6): It was commented that the rules should be clarified to state the plan is developed collaboratively with the client and should include internal coping strategies. DHS changed the definition to "a written plan developed for discharge in collaboration with the individual receiving crisis stabilization services to identify the problem, prevention strategies, and management tools for future crises."

"Crisis stabilization community-based services" and "crisis stabilization residential services" definitions (page 7): It was commented that the difference between the two services was not clear. DHS responded by changing the definitions to clarify that the overall service is the same and the difference is that CSRS involves the need for a short term alternative living situation. Karen said that the words "community-based" do not always have the same meaning to everyone, and Renee noted that the terms used come from the original legislation and Iowa Code, so cannot be changed in the rule.

The definition of crisis stabilization community-based services (CSCBS) means "short term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and provide where the individual lives, works, or recreates." The definition of crisis stabilization residential services (CSRS) means "a short-term alternative living arrangement other than a person's primary residence, designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis in organization arranged settings of less than 16 beds."

"Stabilization plan" definition (page 7): It was commented that the definition should say the plan is written by crisis response staff rather than a mental health professional and in collaboration with the individual rather than with the consent of the individual. DHS responded by indicating that it is felt the plan should be completed by a mental health professional through collaboration with crisis response staff. The definition was changed to "a written short-term strategy used to stabilize a crisis and developed by a mental health professional, in collaboration with crisis response staff and the involvement and consent of the individual or their representative."

"Warm line" definition (page 8): It was commented that in addition to using peer counselors to operate the warm line, crisis response staff or non-peer staff should be used. DHS agreed that the definition had been unclear. The intent was for a warm line to be operated by peer support specialists and family support peer specialists, which follows the national model. The definition was changed to: "a telephone line staffed by individuals with lived experience who provide nonjudgmental, nondirective support to an individual who is experiencing a personal crisis."

Kathy Johnson asked if peer support specialist means a certified peer support specialist. Karen responded that the definition of peer support specialist is the one already used in Chapter 25. It does not specify certification. Renee Schulte added that there are not currently enough certified peer support specialists to meet the need, but training may be linked with certification in the future.

"Peer support services" definition (page 8): It was commented that the terms peer support and peer counseling were used in the rules and not defined. DHS responded that the term peer counseling was removed, and that definitions for peer support services, peer support specialist, and family support specialist were added.

"Crisis incident" definition (page 9): One commenter asked if the definition of crisis reporting applies only to physical injury or death resulting from a medication error. DHS responded by making some changes to the definition to clarify that it applies to any one of

the situations listed. Crisis incident means "an occurrence leading to physical injury or death, or an occurrence resulting from a prescription medication error, or an occurrence triggering a report of child or dependent adult abuse."

Standards for crisis response staff (page 11): It was commented that accreditation of staff through the American Association of Suicidology (AAS) or Contact USA should be considered as an alternative to the trainings required by the Department. DHS responded by changing the rule to allows deeming through those two organizations.

Mental or behavioral health experience (page 11): It was commented that some categories for bachelor level staff indicate behavioral or mental health experience is required and some only seem to accept mental health experience. DHS responded that the discrepancy was unintentional and changed all references to include both behavioral and mental health experience.

Crisis evaluation (page 15): It was commented that crisis screening seems to be required to be available 24/7 and suggested it would be a valuable service that might not have to be available at all times. DHS responded that it believes the availability of screening whenever needed is important. Even so, the performance indicator is being reworded to read, "Crisis response staff are trained in crisis screening; a uniform process for crisis screening and referrals is outlines in policies and procedures; crisis screening records are kept in individual files." Each service category specifies if that particular service must have 24/7 screening available, depending on where the service fits; in some cases a screening will already have been completed.

Physical health assessment (page 15): One commenter asked what was meant by including physical health in the assessment in addition to medical history. DHS responded by changing the definition of crisis assessment to "a face-to-face clinical interview to ascertain an individual's current and previous level of functioning, potential for dangerousness, physical health, psychiatric and medical condition. The crisis assessment becomes part of the individual's action plan." Physical health means any chronic or acute health factors indicated in the crisis assessment that need to be addressed during crisis stabilization service delivery.

Twenty-four hour crisis response (page 16): It was commented that the requirement for at least one ARNP, physician assistant, or psychiatrist be available for consultation 24 hours a day would be costly and unnecessary. DHS responded that it feels the availability of clinical consultation is important, and can be accomplished through a consultative arrangement. The wording was changed to "a mental health professional is available for crisis assessment and consultation 24 hours a day, 365 days a year. The mental health professional has access to a Qualified Prescriber for consultation." The wording "an advanced registered nurse practitioner, physician assistant or psychiatrist is available for consultation 24 hours a day, 365 days a year" was removed.

Twenty-four hour crisis line (page 16): It was commented that that 24-hours crisis line should be answered live, as is the requirement for the warm line. DHS responded that the intent was always that it should be answered lien and changed the language to clearly

reflect that requirement. The rule now reads, “Policies are in place regarding how the crisis line is answered live, when to utilize the hold feature, the use of queue systems and triage of calls.”

Twenty-four hour crisis line (page 17): It was commented that 24-hours crisis lines should provide crisis counseling and crisis screening. DHS responded by adding the word “counseling” to the definition to make that clear.

Twenty-four hour crisis line (page 19): It was commented that the description of mobile response says 24-hours access to a mental health professional is required and suggested that the same should apply to the 24-hour crisis lines that will be dispatching the mobile teams. DHS agreed and added the requirement. The new wording “twenty-four hour access to a mental health professional is required” has been added to the performance indicators for Twenty-four hour crisis line and warm line.

Mobile response (page 20): It was commented that mobile responders should be dispatched after the provision of phone counseling rather than a specific amount of time after the call was received, and that it would not be possible to dispatch mobile response staff in less than 15 minutes if they are already responding to another call. DHS agreed, removed the reference to 15 minutes, and changed the wording of the rule to “dispatch mobile response staff immediately after crisis screening has determined the appropriate level of care. If the mobile response staff is already responding to another call, explain to the caller there may be a delay in getting a mobile response and offer an alternative response.”

Tracking and trending data (page 21): One commenter asked if diversions from hospitals should be tracked as well as diversion from inpatient and jail. Two commenters asked for clarification on what is meant by diversion and suggested that the data collected be shared with MHDS regions. DHS responded by changing the wording of the rules to “Data is collected to track and trend response time from initial dispatch, the time to respond to dispatch when a team is already in response; diversion from or admission to hospitals, correctional facilities and other crisis stabilization services.” Data could be shared with MHDS regions, but it is not required by the rule.

Action plan (page 22): It was commented that the action plan should be given to the individual as well as to service providers with the proper consent. DHS responded by changed the working to clarify that “when an action plan is developed, a copy is sent within 24 hours, with the individual’s signed consent, to service providers, the individual and others, as appropriate.”

Mobile response (page 23): It was commented that the standard requiring mobile response within 60 minutes should be longer on nights, weekends, and if staff are already responding to other calls. DHS responded that the standard will remain in the rule, although there will be times when the standard is not met. The language says “mobile response staff have face-to-face contact with the individual in crisis within 60 minutes from dispatch. If the mobile response staff are responding to another request, they may be a delay in getting mobile response and an alternative response should be provided.”

Tom Bouska asked if there will be sufficient numbers of teams deployed around the state so that the time is reasonable. Karen responded that DHS knows there will be places that do not have teams close enough, but the rules are structured so providers will not be penalized. DHS wants to gather data and work toward meeting the 60 minute standard statewide.

Marsha Edgington asked what an example of an alternative response might be. Renee and Karen responded that it could be calling EMS, the local police, a family member or someone to check on the person so they are not just left in crisis. The call could also be triaged to another service such as a warm line or crisis line.

Documentation (page 23): It was commented that the rules required the organization to have documentation in the individual's service record on evaluation and criteria for admission to inpatient psychiatric hospital care and yet only the designated psychiatric provider for a hospital's inpatient unit may direct orders for admission. DHS agreed and changed the wording of the rule to remove the reference to "evaluation criteria for admission to inpatient psychiatric hospital care."

Mobile response staff (page 24): It was commented that the rules require mobile response staff to respond in pairs to ensure the safety of the providers and the individual served and suggested adding language allowing one person to respond when there is clear reason why that would be safe, such as responding to an emergency room setting. DHS responded by clarifying the language to "Staff work in pairs to ensure their safety and for the individual served. A single staff may respond if another person who meets one of the criteria listed in paragraph 24.24(2)(a) will be available on site."

Mobile response post discharge contact (page 24): One commenter suggested that the requirement for an organization to document contact with the individual served at 10, 30, and 60 days post discharge be changed. DHS responded by changing the language to "A follow-up appointment with the individual's preferred provider will be made and mobile response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place."

Mobile response contact with family members and others (page 25): One commenter asked how the requirement for organizations to have a plan to demonstrate phone contact for parents and significant others is different from contacting providers, family members, and natural supports with 23 hours of admission. DHS agreed that the statements are similar and changed the language to "individuals give informed consent." The indicator, "Treatment providers, family members and other natural supports as appropriate are contacted within 23 hours of the individual's admission," remains the same.

23-hour crisis observation and holding (page 26): One commenter asked if there are requirements for contact with the individual post discharge from 23-hour crisis observation and holding, similar to the follow-up requirements for mobile crisis response. DHS responded by adding the same follow-up requirement to 23-hours crisis observation and holding, "A follow-up appointment with the individual's preferred provider will be made and

mobile response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place."

Crisis stabilization community-based services (page 26): It was commented that follow-up within 24 hours of discharge should be required for CSCBS. DHS agreed and added, "A follow-up appointment with the individual's preferred provider will be made and mobile response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place."

CSCBS environments (page 27): It was commented that the rules do not clearly define the environments where CSCBS can be provided and asked if DHS could provide examples. DHS responded by changing the definition of CSCBS to "short term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis in a community-based setting." The definition of Crisis Stabilization Residential Services (CSRS) was also changed to provide more clarity: CSRS "means a short-term alternative living arrangement other than a person's primary residence, designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis in organization arranged settings of less than 16 beds."

CSCBS staff (page 28): It was commented that the staffing requirement for CSCBS does not state staff must be awake 24/7. DHS responded by changing the language to "Crisis Response staff must be awake and attentive 24 hours a day."

CSCBS mental health professionals (page 28): One commenter suggested re-wording the language related to mental health professionals. DHS agreed and changed the language to, "Mental health professionals provide services with expertise appropriate to the individual's needs."

Crisis stabilization residential services (page 29): It was commented that requiring documentation for stays beyond 3 to 5 days is confusing. DHS agreed and changed the wording to "require documentation for stays of more than 5 days."

DISCUSSION - Jill Davisson said the commenters made some good point that helped to improve the rules. Patrick noted that a tremendous amount of work has been done by DHS and others to develop these rules and by commenters who reviewed and gave their input. Karen Hyatt noted that there were a number of comments about staff training, but not substantive changes were made. The Department tried to reassure providers that many of the trainings they are already using could be approved by DHS for these training requirements. The Department did not want to be too specific so that training options will be flexible. Theresa Armstrong noted that the same process currently used by Chapter 24 providers to get training approved will be used. The Department maintains a list of trainings that have been approved and it can be shared with providers and others.

April Adams-Knudsen asked why crisis stabilization residential services require a justification for more than 5 days. Renee Schulte responded that, generally speaking, an individual would be expected to move to another level of service by 5 days. If the

individual goes to transitional housing or another type of service, that could be tacked on to the 5 days. The rule also allows more than 5 days with justification.

Teresa Bomhoff asked if an individual who had been receiving crisis stabilization residential services could potentially continue to receive a lesser level of care in the same facility. Theresa Armstrong responded that that is possible. She said Magellan has reviewed the rules and they will determine, based on the services they are already paying for, where these services will fit into the payment codes and how they will be covered. Renee Schulte added that these services are intended to be provided without regard to the funding stream. Regions are responsible for making them available, although they may be supported by Medicaid or other sources of funding.

Teresa Bomhoff asked what the time table will be for the rules if the Commission approves them today. Theresa Armstrong responded that they will go to the Administrative Rules Review Committee in November and would have an effective date of December 1. Providers who want to be accredited would need to file an application. The review process usually takes about three months. Renee Schulte noted that this will be a major topic at ISAC (Iowa State Association of Counties) Fall School in November.

Sharon Lambert asked how individuals will know that they can access these services. Patrick Schmitz responded that providers are aware they will need to advertise what they have to offer and are going to want to use flyers and other ways of getting the information out so that people will seeks the services. Information can also be shared through the integrated health homes, as well as doctor's offices, and many places in the community.

Patrick asked what ability regions have to tell providers to seek reimbursement from health insurance companies rather than billing the region. Suzanne Watson commented that she thinks many of these services will have to be set up on an annual budget basis, rather than fee for service, because they need to be available all the time, not just when someone is in need. Patrick agreed, saying that if a CMHC (community mental health center) takes a crisis call, they cannot bill insurance for it because there is no applicable billing code. Deb Schildroth commented that she could see counties/regions shifting back to block granting money for services rather than paying fee for service for the provision of some of these types of services. April Adams-Knudsen said Eyerly Ball bills Magellan for those services that can be covered under Medicaid; there is a process in place.

Motion and Vote – Suzanne Watson made a motion to adopt the Administrative Rules for Crisis Response Services as presented. Jill Davisson seconded the motion. No further discussion was offered. The motion passed unanimously with 15 members present and voting.

REMARKS BY DIRECTOR PALMER

DHS Director Chuck Palmer congratulated everyone on their hard work and noted that good movement is continuing. He said there is a lot going on and he wanted to come to the Commission meeting to share some thoughts. The Iowa Health and Wellness Plan (IHAWP) went into effect January 1 and MHDS redesign went in effect July 1; these two

major reforms are doing very well, but still in their first year. About 110,000 individuals have enrolled in IHAWP and are getting access to health care. The new dental program began May 1. About 17,000 people have accessed dental care through that program. ACOs (Accountable Care Organizations) are moving ahead and integrated health homes (IHHs) have moved into Phase 3, so are now operating statewide.

Director Palmer said he was struck by the dimension and complexity of the issues as he listened to the discussion on crisis services this morning and wanted to thank everyone for their hard work. He said he is impressed by the quality and the depth of the work.

He said that the principles driving us – the importance of access, quality, and flexibility; the integration of services; person-centered; affordable – all showed up in the comments and questions. It is a complex integration of mental health services and police and sheriff's departments across sectors. Crisis systems are not going to looks the same in Des Moines as they do in smaller towns and more rural areas. Peers have already done some amazing things to fill the gap that traditional mental health systems have not been able to fill and that will continue.

Director Palmer said the discussion raised some important issues on provider quality and the challenge of setting a floor of competency and still allowing flexibility. The discussion also raised the question of what constitutes a crisis. Is it a five day event? What about the sixth day or the fifteenth day? If it is viewed as an isolated event, then the prevention and follow-up that are needed to break the crisis cycle will not be done. Crisis services need to be integrated into the continuum of services and housing also needs to be addressed as a part of that. Great progress is being made, but more discussions are still needed around the over-riding principles that cut across core services, how to ensure integration between them, and see how it all fits together into a larger, and more holistic picture. He said that in too many cases the questions raised can become barriers or reasons not move forward, but with discussion and consideration, the stakeholders can come together to work through the barriers and create a better system.

The coming elections will effect who the decision makers will be at both the state and federal level. New people will be coming into the legislature. This will be a very challenging session financially. Since going through the recession, Iowa has enjoyed good economic times for the last few years. That has resulted in a significant loss of federal Medicaid money because, comparatively, Iowa is doing much better than many other states. The reduction in federal funds coming into the state will be about $80 million over the period of time. Since the legislature did not fully fund Medicaid during the last session, that difference will have to be made up. State revenues are not going well. The agricultural crop projections are good, but revenue projections are coming in low, and commitments have been made in the area of education reform and tax cuts and those bills are going to be coming due. It required a proposal of well over $200 million dollars for the Department just to stay at status quo.

Director Palmer said that he did not recommend equalization in his budget proposal, and he is going to ask that equalization is carefully reviewed to see how it should be continued and if it is doing what it was intended to do. By the end of the week, he said he should

have a sense of where the counties and regions are in the Medicaid Offset and who will be depending on the equalization money. He anticipates it will be about five regions.

He said this will also be a time to look at how we are using the Community Mental Health Services Block Grant and other income revenues from the Iowa Health and Wellness Plan. The Social Services Block Grant, which is about $11 million, has been used for funding state cases and it is time to consider if that is still the best way to use the money. He said he will be putting together a report for the Governor and the Legislature recommending that a more informed discussion take place. That report should be ready to share in December. Funding Medicaid is going to be a major point of discussion. There is not going to be new money and all possible sources will need to be examined. He said he expect it to be a tough year. It will be important to continue doing what we are doing – focusing on our vision, providing services, and keeping the momentum going. The Department and stakeholder will need to work together to build services and figure out how to meet the need.

Director Palmer concluded by saying that the time and attention the Commission and others have invested in the careful vetting of the crisis rules is very important and has helped them get through the complex rule process.

DHS/MHDS UPDATE

Theresa Armstrong updated the Commission on DHS/MHDS activities.

Community Services MH Workgroup – A workgroup for community based service options for persons with mental illness is being formed. This group was called for by the legislature. The Department is in the process of making contacts and finalizing the membership. The workgroup has to have representation from specific groups and agencies, including the Iowa Behavioral Health Association, the Iowa Association of Community Providers, DIA, and the Department on Aging (IDA), as well as additional providers and stakeholders. The meetings are expected to start in October. A report is due to the legislature in December.

HCBS Settings Rules – The rules that were released by CMS (Centers for Medicare and Medicaid Services) earlier this year required that states review how well they meet the standards in the rules and submit plans to get into compliance within five years. Providers are going to have to do some reviewing and make sure that they are meeting the requirements. The initial plan had to be submitted by IME by the end of July. Iowa's plan had to be submitted early because our ID Waiver was up for renewal. No feedback from CMS has been received yet. The complete statewide plan must be submitted by December 25. Information gathered during the series of public meetings will be used to inform the final plan and the Department will probably be seeking some additional input before it is completed. The information is available on the DHS website.

IHAWP – There are currently about 110,000 enrollees. Magellan has started providing some data about medically exempt paid services. Since January 1, 18,850 people have been identified as receiving behavioral health services. That is about 14% of the total

enrollees. The number of people identified as medically exempt is currently just under 12,000. About 5400 of them have had a claim with Magellan, which is about 47% of the number who could be eligible for behavioral health services.

Kathy Johnston asked if the review of claims data to identify people who could quality as medically exempt will continue on an ongoing basis. Kyle Carlson indicated that the intent is to do a claims review on a periodic basis.

Teresa Bomhoff asked what the standard is for identifying people as medically exempt from Medicaid claims and how many people have been identified as medically exempt through claims data. Kyle Carlson responded that the identification is based on diagnosis. He said he did not have the most recent numbers, but it is somewhere around 4000.

Mike Polich asked how the search for a new Medicaid Director is progressing. Director Palmer responded that work is being done on job specifications and there will be a national search, which will probably be conducted after the elections. He noted that there may be more candidates available after the elections because of changes in state appointed personnel in other states and that anyone coming into the job would want the clarity about the political climate that will come after the elections.

Deb Schildroth asked if when people are re-enrolled that have been medically exempt if the medically exempt designation will be automatic upon re-enrollment, of if they will have to go through the process again. Theresa responded that she will have to get more information from IME on exactly how that will work. Tom Bouska did some checking and said that review forms will be going out with the medically exempt question, so it should be possible to identify people from that. He also noted that 50% of the enrollment applications that are coming in are paper applications, which speaks to the access and capacity of people to use computerized systems. It also means there is a continuing demand on income maintenance workers to deal with those applications.

Sharon Lambert asked what mechanisms will be put in place for tracking the quality of services provided. Will there be consumer or family surveys or a phone line for comments? Theresa Armstrong responded that the Department continues to meet with advocate groups and get feedback from the Commission and the Mental Health Planning Council. She said a consumer survey will also be developed. Sharon commented that she is her grandson's guardian and has found it frustrating that she is not always granted access to information about him and her signature as guardian is not always accepted. Suzanne Watson agreed that she has also known that to happen.

MEDICAID OFFSET RULES

Theresa Armstrong explained that the Medicaid Offset rules have been publicly noticed. The public comment period has ended and not public comments were received. They s rules should go into effect by the due date established in the rules for data submission, which is September 19. The earliest they can complete the rule-making process and become effective is September 25. The Department would like the Commission to schedule a special telephone meeting for September 25th to review the minutes and vote

on approving them to go into effect as emergency after notice. Patrick Schmitz asked Connie Fanselow to set up a telephone meeting for 9:00 am on Thursday, September 25 and send out public notice of the meeting, along with the final draft of the rules.

PUBLIC COMMENT

Jess Benson announced the John Pollock, of the Legislative Services Bureau, is retiring next week and there will be a party at the Capitol. John has been doing all the mental health drafting for about 25 years. Everyone is invited to come to Room 116 in the Capitol from 1:00 to 3:00 p.m. on September 25 to wish him well. Patrick Schmitz commented that John has been an amazing resource to anyone working in the mental health world and his expertise will be missed.

Teresa Bomhoff shared some copies of a proposed change in the IME drug utilization policy that would require new prior authorization for use of many antipsychotic medications for children, youth, and adults. She said the proposal would restrict certain medications for reasons associated with age for children. Teresa said IME plans to start implementing the new policy in the spring for children. Prior authorization for the use of duplicate or multiple antipsychotic therapies for adults will be initiated in a later phase. She encouraged the Commission to have IME come to a future meeting to discuss the change. She said she believes it will have an impact on many people who are on more than one antipsychotic medication and there is concern about changing medication for people who are stable and doing well on their current medications. She said that NAMI (National Alliance on Mental Illness) is advocating for open access to medications and this new guideline is moving in the other direction.

Break for lunch was taken at 12:00 p.m.

The meeting resumed at 1:00 p.m.

SUBACUTE ADMINISTRATIVE RULES

Jim Friberg, from the Department of Inspections and Appeals gave an update on the status of the subacute administrative rules. The notice of action went to the ARRC (Administrative Rules Review Committee) last week. There were no comments from the public and no discussion with the Committee. There will be a public hearing at 10:00 am on September 24 in Room 320 of the Lucas Building. It is anticipated that the rules will go into effect sometime in December. DHS is responsible for issuing the RFP (Request for Proposals) for establishing the subacute care beds authorized by the legislature. Theresa Armstrong noted that the Department is in the very early stages of developing the RFP and there is not yet an exact time frame, although it will be after the first of the year. Iowa Code authorizes 50 beds to be established across the state.

Patrick Schmitz noted that he has been asked what the difference is between crisis services and subacute services and how they fit together, because in many ways they look similar. He said it helped him to think about them as “bookending” a crisis. In general, crisis services are designed to help prevent, diminish, or manage a crisis and subacute

services are more likely to be used as an intermediate step between acute care and return to a stable community living situation.

Update from Story County - Deb Schildroth shared some information on changes in services in Story County. Many people are familiar with Story County Community Life in Ames, which is a county-operated program that was developed by the county in 1990 when the county care facility home was closed and people were moved into the community. It serves about 210 clients, has three eight-bed residential care facilities, five 24-hour-staffed sites for individuals with ID and health issues, a supported employment program, day habilitation program, and a nursing/medical services program.

As the Central Iowa Community Services Region was coming together, they looked at all county-operated programs. Story County Community Life had been subsidized by the county at a cost of about $1 to $1.5 million per year. It would have been necessary to cut services significantly to reduce that cost. As part of a collaborative effort by Story County and the regions, a consultant, Parker Denison, from Arizona, was contracted to conduct a financial and clinical review. They recommended privatizing the services. Yesterday an RFP for those services was released. The RFP and a resource file are available on the Story County website. The resource file includes information about properties, assets, services, and cost reports for prospective bidders.

Deb said that ideally one bidder would be able to do everything, but parts could be subcontracted. A bidders' conference will be held on October 1. The plan is to have a contract in place by January 1. January to June would be the transition period. This will be a big change for Story County and the region and they are committed to doing it in the least disruptive way possible for clients. They have been talking to clients and family members and answering questions along the way. Deb said they do not want individuals to have to move or change providers. The intent is for services to continue in much the same way, but under a different structure.

MULTI-OCCURRING TRAINING INITIATIVE

Mary Mohrhauser shared an update on the multi-occurring training initiative. Dr. Ken Minkoff and Dr. Chris Cline of Zia Partners in Arizona have been under contract with the Department to come to Iowa four times a year for 3 days to provide training and technical assistance. The initiative started as "co-occurring" to address the needs of people with both mental health and substance use issues. In 2011, it was broadened to include intellectual and developmental disabilities, brain injury, and all multi-occurring service needs.

Mary shared a handout developed by Zia Partners to crosswalk the intersection of "multi-occurring" in adult mental health services, "trauma informed care" in children's services, and "positive behavior supports" in ID/DD services. Work was done to look at and consider what providers were already doing that fits into the culture of the service delivery system and how they could better meet the needs of people with multiple and complex service issues. Drs. Minkoff and Cline conducted "change agent" trainings at locations across the state 4 times a year and have trained about 900 people. The trainings have

since been divided into two parts – one that is orientation training for people who are new to the concept and one that is for people who are working on culture changes in their organizations and want to keep moving the process along. Drs. Minkoff and Cline also spend two days four times a year meeting with providers, and now with regions and regional administrators, to hold technical assistance sessions.

Mary said that providers have been very interested in the initiative, but it takes time to include programs and staff at all levels, even those such as maintenance and transportation staff who do not directly deliver services, and immerse everyone into this way of doing business. Patrick Schmitz noted that his agency has been involved since the beginning and there has been tremendous change in the last five years. He said the really making culture change means really working on it every day and that can be challenging, especially at a time when there are so many other changes happening.

The current contract ends on March 31, 2015. The Department will need to determine what the next step is in the process of changing business culture to be more welcoming and prepared to address multi-occurring issues. If it is determined that the training and technical assistance process should continue, there will be a new RFP issued. DHS and providers will continue to consider how services can be delivered differently to better address multi-occurring needs. In the case of children's services, it means looking at what the child needs and also at what the whole family needs and addressing that all together. People are complex and solutions need to be multi-faceted.

PUBLIC COMMENT

No additional public comment was offered.

Theresa Armstrong told the Commission that she wanted them to know that Chuck Palmer had read and considered their cost increase recommendation letter. His budget recommendation had been that all core services are covered first, and then any additional funds available to the regions be used for justice involved and crisis response services.

COMMITTEE WORKGROUPS

Three Commission committees met from 1:40 to 2:30 p.m.

The Legislative Recommendations Committee members participating were Tom Broeker, Lynn Grobe, Marilyn Seemann, and Patrick Schmitz. They reviewed the previous edits to last year's recommendations and made additional revisions. Connie Fanselow will consolidate their notes into a draft for review.

The County-Regional Services Committee members participating were Deb Schildroth, Rebecca Peterson, Richard Crouch, Kathy Johnson, Sharon Lambert, and Tom Bouska. Deb Schildroth will put together draft summarizing their discussion and send it to the other committee members for review.

MHI and SRC Services Committee members participating were Neil Broderick, Suzanne Watson, Marilyn Seemann, and Marsha Edgington. The committee reported they do not feel there is any real outcome data available; there is quantitative data, but not qualitative. Suzanne Watson will create a draft of what the group thinks is needed to collect outcome data and report on it. She will email her draft to other members to add or edit and then forward the summary to Connie.

NEXT MEETING

The next meeting of the MHDS Commission is scheduled for Thursday, October 16, 2014. The meeting will be at ChildServe (Training Center), 5406 Merle Hay Road in Johnston. It will be a joint meeting with the members of the Iowa Mental Health Planning and Advisory Council.

The meeting was adjourned at 2:30 p.m.

ADDENDUM
September 25, 2014 Telephone Meeting

A telephone meeting of the MHDS Commission was held at 9:00 a.m. on Wednesday, September 25, 2014. The only item on the agenda was to review and vote on approval of the administrative rules for submitting Medicaid Offset data.

Members participating - Thomas Bouska, Neil Broderick, Thomas Broeker, Richard Crouch, Jill Davisson, Marsha Edgington, Kathy Johnson, Geoff Lauer, Brett McLain, Rebecca Peterson, Michael Polich, Deb Schildroth, Patrick Schmitz, and Suzanne Watson. Theresa Armstrong and Melissa Havig were also on the call.

Patrick Schmitz called the meeting to order at 9:02 a.m. and quorum was established with 14 members present by phone. No conflicts of interest were identified for this meeting.

Discussion – Members had reviewed the proposed rules and no additional comment or discussion was offered.

Motion & Vote – Jill Davisson made a motion to approve the administrative rules for submitting Medicaid Offset data to be adopted as emergency after notice. Tom Bouska seconded the motion. The motion passed unanimously.

The meeting was adjourned at 9:10 a.m.

Minutes respectfully submitted by Connie B. Fanselow.